APPLICATION FORM

MAT Paratransit for Persons with Disabilities

This application form is used by MATBUS to determine eligibility for MAT Paratransit for persons with disabilities with limited ability to use the MATBUS fixed route service in the cities of Fargo/West Fargo, North Dakota and Moorhead/Dilworth, Minnesota. **Those applying for discount fare on the MATBUS fixed route only due to disability and not Paratransit must complete a different application form.** Anyone who is Paratransit eligible is automatically eligible for discount fare on the MATBUS fixed route.

A complete application includes:

- ❑ **Application Form:** Please complete this form.
- ❑ **Authorization Forms:** Identify a professional familiar with your disability and sign the **blue authorization** form. Please sign the **white Sanford** form if you have a Sanford provider.

MATBUS sends a form to verify your disability to the professional you identify on the authorization form. A final determination of eligibility will occur within 21 days of receiving the application form, authorization form, and professional verification form. If Paratransit eligibility is denied, the reason for the finding will be included in a letter along with a description of the appeals process.

SEND COMPLETED APPLICATION FORM TO:

MATBUS
650 23 St. N.
Fargo, ND 58102

Transit Office: 701.241.8140
Fax: 701.241.8558
TDD/Relay: 7-1-1

Please contact us if you have any questions or need help completing the application.

Please print your answers to the following questions.

1. **Are you only applying for Paratransit eligibility?** Yes ☐ No ☐

   Paratransit eligibility automatically includes discount fare on the MATBUS fixed route. If you only want to apply for discount fare for MATBUS fixed route due to disability or age, please complete the application for discount fare.

2. **Last Name** _____

   First Name _____ **Middle Initial** _____

3. **Address** _____

   _____

   City _____ **State** _____ **Zip** _____

4. **Telephone Number**: _____

5. **Date of birth**: ____/____/____ **Gender**: Male ☐ Female ☐

6. **Do you have a physical or mental impairment?**

   Physical ☐ Mental ☐ Both ☐

7. **What is your disability?**

8. **Is this condition temporary?** Yes ☐ No ☐
   If Yes, what is the expected duration? / /

9. **Does this disability *prevent* you from using MATBUS Fixed Route Bus Service (the city bus) independently?** For instance: to utilize Fixed Route Services (city bus), you may need to travel up to 1/4 mile to the bus stop, wait outside for up to 10 minutes, and be able to navigate the system (recognize destinations, understand transfers, distinguish between vehicles).
   Yes ☐ No ☐ Sometimes ☐

10. **How does this disability prevent you from using MATBUS Fixed Route Service?** If you answered "sometimes" in question nine, please explain.

11. **Do you need to bring a Personal Care Attendant (PCA) to assist you when you travel?**
    Yes ☐ No ☐ Sometimes ☐ (explain)

12. **Will you *regularly* need the driver to help you to/from the first door of your origin or destination?**
    Yes ☐ No ☐ *If yes, the MAT Paratransit driver is only allowed to help through the first door of the building.*

13. **Do you use any of the following aids to mobility? (*Check all that apply*.)**

    ☐ electric wheelchair ☐ manual wheelchair
    ☐ scooter ☐ walker
    ☐ cane ☐ crutches
    ☐ guide animal ☐ oxygen tank
    ☐ other:

14. **If you use a mobility device, is the combined weight of you and the wheelchair/scooter more than 800 pounds when using the wheelchair lift?**
    Yes ☐ No ☐

15. **If you use an electric wheelchair, can you operate the controls yourself?**
    Yes ☐ No ☐ *If not, the passenger is responsible for bringing a PCA on MATBUS and MAT Paratransit. The driver is not allowed to operate controls of an electric wheelchair.*

16. **Are you capable of traveling in a vehicle with strangers without supervision for up to an hour?**

Yes ☐ No ☐ *If not, the passenger is responsible for bringing a PCA on MATBUS and MAT Paratransit. The driver does not provide supervision, direct a passenger unable to travel independently or ensure a passenger is not left alone at the destination.*

17. **Does the weather and/or environment impact your ability to use MATBUS?**

Yes ☐ No ☐

If yes, what conditions limit your ability to use MATBUS?

☐ temperatures above 85 degrees ☐ temperatures below 32 degrees
☐ snow and ice ☐ unsafe street crossing
☐ hours of darkness ☐ uneven pavement or surfaces
☐ other: _____

18. **Does your disability affect your ability to physically travel in the community?**

Yes ☐ No ☐ Sometimes ☐ _____

If you answered "NO" to Question 18, skip to Question 22

19. **Can you travel the following distance outside *without* the assistance of another person? <u>Travel includes using mobility aids</u> such as a wheelchair, walker, cane, etc.**

200 feet (about 1/2 block)
Yes ☐ No ☐ Sometimes ☐ (explain) _____
440 feet (about 1 block)
Yes ☐ No ☐ Sometimes ☐ (explain) _____
880 feet (about 2 blocks)
Yes ☐ No ☐ Sometimes ☐ (explain) _____
1/4 mile (about 3 blocks)
Yes ☐ No ☐ Sometimes ☐ (explain) _____
1/2 mile (about 6 blocks)
Yes ☐ No ☐ Sometimes ☐ (explain) _____
3/4 mile (about 9 blocks)
Yes ☐ No ☐ Sometimes ☐ (explain) _____

20. **MATBUS fixed route buses and Paratransit vans all have ramps or lifts. Do you require a ramp or lift instead of stairs to enter a vehicle?**

Yes ☐ No ☐ Sometimes ☐ (explain) _____

21. **Can you wait outside without support for ten minutes?**

Yes ☐ No ☐ Sometimes ☐ (explain) _____

22. **Do you have a mental or psychological disability?** Yes ☐ No ☐

23. **Do you have a sight impairment, or are legally blind?** Yes ☐ No ☐

If you answered "NO" to questions 22 and 23, skip to question 26

24. **Are you able to…**

give addresses and telephone numbers upon request?

Yes ☐ No ☐ Sometimes ☐ (explain)

recognize a destination or landmark?

Yes ☐ No ☐ Sometimes ☐ (explain)

deal with unexpected situations or unexpected change in route?

Yes ☐ No ☐ Sometimes ☐ (explain)

ask for, understand and follow directions?

Yes ☐ No ☐ Sometimes ☐ (explain)

learn how to make a transfer to another bus?

Yes ☐ No ☐ Sometimes ☐ (explain)

demonstrate personal safety skills? (e.g. dress for weather, stranger interaction)

Yes ☐ No ☐ Sometimes ☐ (explain)

25. **Do you need the Paratransit brochure in an alternate format?**

Large Print ☐ CD ☐ Language other than English ☐

26. **If approved would you like to sign-up for trip reminders?**

Email ☐ Phone ☐ Both Email and Phone ☐ Email

27. **List the name of one person or agency that we may contact in the case of an emergency.**

Name

Telephone Day Evening

28. I hereby certify that the information given above is correct.

Signature Date

29. **If someone other than the person requesting MAT Paratransit completed this application, please complete the following**

Name

Agency/Relationship to Applicant

Address

Telephone Work Cell

Signature Date / /

30. **If we have questions on your application, we will contact you.**

Would you rather we contact the person/agency who filled out the application on your behalf listed above? Yes ☐ No ☐

**By answering yes, you are authorizing MATBUS staff and the person listed above to discuss your medical information.*

AUTHORIZATION FORM

Name of Applicant: _____

In order to allow MATBUS to evaluate your eligibility for MAT Paratransit for persons with disabilities, it may be necessary for us to contact a physician or other professional with access to your medical records to confirm the information you provided. If you do not allow MATBUS to contact your physician or other professional, we will not be able to process your request. Please include this Authorization Form completed by you with your application. **If you have a Sanford medical provider, please complete the Sanford authorization form provided.**

The person listed below is familiar with my disability and is authorized to complete the professional verification form that MATBUS requires to determine my qualifications for MAT Paratransit for persons with disabilities. Once this information is provided to MATBUS, it may be subject to redisclosure and no longer protected by the privacy rule.

FILL IN THE FOLLOWING INFORMATION ON A PHYSICIAN OR PROFESSIONAL WHO IS FAMILIAR WITH YOUR DISABILITY -- ***PLEASE PRINT***

The individual listed below is a:

- ☐ Physician
- ☐ Health Care Professional
- ☐ Rehabilitation Professional
- ☐ Social Service Agency Professional with access to medical records

Physician's or Professional's Name _____

Clinic or Business Name _____

Address _____

City _____ **State** _____ **Zip** _____

Work Phone _____ **FAX** _____

The application process can go faster if the professional's fax number is available.

I understand I have a right to revoke this authorization. This authorization will expire on (date/event) _____ OR automatically 12 months from date of signature.

Signature of Applicant

_____ Date ____/____/____

NOTE: ***Any medical fees associated with providing this information are the responsibility of the applicant or client, and not the Cities of Fargo or Moorhead or MATBUS.***

For use if you have a Sanford Provider

SANFORD HEALTH

Authorization for Disclosure of Protected Health Information

Internal use only Sanford Health MRN	**Patient Name**: _____ **Date of Birth**: _____ **Full Address:** _____ **Phone Number**: _____ **Maiden/Previous Names** _____

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release Information From:

Name/Facility: Sanford Health Systems
Address: PO Box MC
City, State, Zip: Fargo, ND 58122
Phone:

Release Information To:

Name/Facility: Metro Area Transit
Address: 650 23rd St. N.
City, State, Zip: Fargo, ND 58102
Phone: 701-235-4464

Purpose of Release:

☐Continuing Medical Care ☐Work Comp ☐Disability Determination ☐ Personal
☐Insurance Claim ☐Application for Insurance ☒Other: At my request

Delivery Method: **Date information desired by:** ASAP

Release Format:

☐ Paper ☐Mail ☐ Pick Up ☒ Fax *(as appropriate)* **Fax #:** 701-241-8558
☐ USB ☐Mail ☐ Pick Up
☐ Electronic via *My Sanford Chart* Patient Portal
☐Release to ALL My Sanford Chart Proxies

Information to be Released:

Service Dates: From: _____ To: _____ **OR** ☐ all future records until this authorization expires
NOTE: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____

☐ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).*

☐ Discharge Summary ☐ ER Records ☐ History & Physical ☐ Clinic Visit Notes
☐ Psychological Evals/Assmts ☐ EKG/Cardiology Reports ☐ Immunization Records ☐ Operative Reports
☐ Lab / Pathology Reports ☐ Radiology Images ☐ Radiology reports ☐ Entire Medical Record
☐ Billing Statements ☒ Other: MATBUS Transportation Verification Form (*charge may apply*)
☐ Alcohol/Drug Treatment Records

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

X Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits

Signature *(required)*	**Date Signed** (required)
Relationship, If Not Patient	